Department of Employee Trust Funds
Group Health Insurance
P.O. Box 7931
Madison, WI 53707-7931

HEALTH INSURANCE INFORMATION CHANGE

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

SUBSCRIBER:
Complete Sections 1-4

Return to employer (if active employee) or the Department of Employee Trust Funds (if retiree or continuant)

Employer Name: _____

1. Name _____ Birthdate _____ SS #_____
   Health Insurance Plan _____ Present Coverage: ☐ Single ☐ Family
   Subscriber #_____ Group #_____
   (If retiree or continuant) I was a dependent or spouse of _____ _____
   (Name) *(Social Security Number)*

2. Check the box(es) indicating the type(s) of change(s): Event Date _____
   - ☐ Name change (list former name) _____
   - ☐ Address change to: Street: _____
     City: _____ State: _____ Zip Code: _____
   - ☐ County _____
   - ☐ Home Phone #_____ ☐ Daytime Telephone #_____
   - ☐ Social Security #_____ for _____
   - ☐ Adding a dependent ☐ Deleting a dependent *[Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]*
     Reason: ☐ Marriage ☐ Divorce ☐ Age ☐ Student Status ☐ Birth ☐ Legal Ward ☐ Adoption
   - ☐ Other _____
   - ☐ Update other insurance coverage for: _____
     Through State of WI? ☐ No ☐ Yes Insurance Company _____
     Group # _____ Subscriber/Policy # _____
     Name of Employer _____ Medicare? ☐ No ☐ Yes
     Name of Insured _____ Effective Date _____
   - ☐ Primary Care Physician Change *(complete #3)* Change in subscriber's physician county ☐ No ☐ Yes
     Effective Date Authorized by Plan _____ Reason for Change _____
     Some plans allow changes at anytime; others do not. Check with your plan, then file this form. The effective date of the physician change is determined by the plan. Any change in your share of premium is effective on the first of the month following receipt of the form by your employer.

3. Complete the following for additions, deletions or when selecting a different primary care physician.

Last Name	First	Middle I.	SS#	Birthdate Mo	Da	Yr	Sex	Relationship To Subscriber	Selected Physician	County	Provider No.

* Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

4. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
   Subscriber Signature _____ Date _____

EMPLOYER COMPLETES AREA BELOW Coding instructions are in the Employer Manual

Enrollment Type	Employee Type	Coverage Code	Carrier Suffix	Standard Plan Waiting Period	Participant County	Physician County	Payroll Representative Signature	Telephone
65								

Name of Employer	Employer Number	Group Number	Date Received by Employer
	69-036-		

Monthly Employee Share	Monthly Employer Share	Date Employment Began *(MM/DD/CCYY)*	Event Date	Prospective Date of Coverage *(MM/DD/CCYY)*
$	$			

FOR CARRIER USE ONLY	SN	FN	PL	ED	Premium Source
					01 02 03 04

Ply 1 – Carrier Copy Ply 3 – Employer Copy
Ply 2 – ETF Copy Ply 4 – Employee Copy